■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam							
Name			Date of birth				
Sex Age Grade Sch	ool		Sport(s)				
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking			
Do you have any allergies? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify sp	ecific al	lergy below. □ Food □ Stinging Insects				
Explain "Yes" answers below. Circle questions you don't know the an	swers t	о.					
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No		
 Has a doctor ever denied or restricted your participation in sports for any reason? 			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?				
2. Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?				
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			28. Is there anyone in your family who has asthma?	\vdash			
3. Have you ever spent the night in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?				
4. Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?				
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?				
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?				
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?	<u> </u>			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?	—			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?				
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?	\vdash			
check all that apply: ☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?				
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?				
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?				
10. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?	ــــــ			
during exercise?			41. Do you get frequent muscle cramps when exercising?	—			
11. Have you ever had an unexplained seizure?12. Do you get more tired or short of breath more quickly than your friends			42. Do you or someone in your family have sickle cell trait or disease?	—			
during exercise?			43. Have you had any problems with your eyes or vision? 44. Have you had any eye injuries?	\vdash			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?	+			
13. Has any family member or relative died of heart problems or had an			46. Do you wear protective eyewear, such as goggles or a face shield?	\vdash			
unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?				
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or lose weight?				
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			49. Are you on a special diet or do you avoid certain types of foods?				
polymorphic ventricular tachycardia? 15. Does anyone in your family have a heart problem, pacemaker, or		-	50. Have you ever had an eating disorder?	<u> </u>			
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?				
16. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY				
seizures, or near drowning? BONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period? 53. How old were you when you had your first menstrual period?	+			
17. Have you ever had an injury to a bone, muscle, ligament, or tendon	162	NO	54. How many periods have you had in the last 12 months?	\vdash			
that caused you to miss a practice or a game?			Explain "yes" answers here				
18. Have you ever had any broken or fractured bones or dislocated joints?							
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?							
20. Have you ever had a stress fracture?		 					
Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)							
22. Do you regularly use a brace, orthotics, or other assistive device?							
23. Do you have a bone, muscle, or joint injury that bothers you?			İ				
24. Do any of your joints become painful, swollen, feel warm, or look red?							
25. Do you have any history of juvenile arthritis or connective tissue disease?]				
I hereby state that, to the best of my knowledge, my answers to		•	·				
Signature of athlete Signature of	of parent/g	juardian _	Date				

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of E	xam					
Name _				Date of birt	h	
Sex	Age	Grade	School			
	of disability					
	of disability					
	sification (if available)					
4. Caus	se of disability (birth, d	isease, accident/trauma, other)				
5. List t	the sports you are inte	rested in playing				1
					Yes	No
		ce, assistive device, or prostheti				
		ace or assistive device for sports				
		ressure sores, or any other skin	problems?			
		s? Do you use a hearing aid?				
	ou have a visual impa					
		vices for bowel or bladder functi	on?			
		scomfort when urinating?				
	you had autonomic d	-				
	•		nermia) or cold-related (hypothermia) illnes	S?		
	ou have muscle spast		, madiantian?			
		ures that cannot be controlled by	/ medication?			
Ехріаііі у	yes" answers here					
Diagon ind	dianta if you have av	or had any of the following				
riease iiiu	uicate ii you iiave ev	er had any of the following.			Yes	No
Atlantoax	rial instability				165	NO
	aluation for atlantoaxia	al instahility				
	ed joints (more than or					
Easy blee		/				
Enlarged						
Hepatitis						
	nia or osteoporosis					
Difficulty controlling bowel						
Difficulty controlling bladder						
	ss or tingling in arms (or hands				
Numbness or tingling in legs or feet						
	s in arms or hands					
Maslessa						
weaknes	s in legs or feet					
	s in legs or feet hange in coordination					
Recent ch						
Recent ch	hange in coordination hange in ability to wal					
Recent ch	hange in coordination hange in ability to wal ida					
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Recent ch Recent ch Spina bifi Latex alle	hange in coordination hange in ability to wal ida ergy					
Recent ch Recent ch Spina bifi Latex alle Explain "y	hange in coordination hange in ability to wal ida ergy yes" answers here	k				
Recent ch Recent ch Spina bifi Latex alle Explain "y	hange in coordination hange in ability to wal ida ergy yes" answers here	k	rs to the above questions are complete a	and correct.		

PHY Name	SIC				HYSICA INATIO				Dat	e of birth	1		
Have you ever toDo you wear a sConsider reviewing	questions on seed out or uni- sad, hopeless at your home ied cigarettes, 30 days, did yo ohol or use an aken anabolic aken any supp eat belt, use a	der a lot of s, depresse or residen , chewing ou use che ny other dri steroids of lements to helmet, a	f pressured, or and ce? tobacco, ewing tolugs? r used aro help yond use c	re? xious? snuff, or dip bacco, snuff, ny other perfo u gain or lose condoms?	or dip? ormance supplement e weight or improve y		nance?						
EXAMINATION			A/=:=l=4			□ Mala	□ Famala						
Height		, V	Neight	D. I			☐ Female		201		0	 	
BP /	(/		Pulse		Vision I	NORMAL	L 2	20/	ADM	Correcte ORMAL		N
arm span > height Eyes/ears/nose/throa	t, hyperlaxity,				xcavatum, arachnoda cy)	ctyly,							
Pupils equal Hearing													
Lymph nodes Heart ^a													
Murmurs (auscultLocation of point				lva)									
Pulses • Simultaneous fem	oral and radia	ıl pulses											
Lungs													
Abdomen													
Genitourinary (males Skin • HSV, lesions sugg		A. tinea co	rporis										
Neurologic °		,	,										
MUSCULOSKELETA	L												
Neck													
Back													
Shoulder/arm													
Elbow/forearm													
Wrist/hand/fingers													
Hip/thigh													
Knee													
Leg/ankle													
	INIT TO SERVICE STATE OF THE S												

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GU exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

	Cleared for	all s	sports	without	restriction
\Box	Cloored for	م ال	norto	that	rootriotion

Duck-walk, single leg hop

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _

□ Not cleared

Functional

□ Pending further evaluation

□ For any sports

☐ For certain sports ___

Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

,	
lame of physician (print/type)	Date
Address	Phone
Smoothers of physician	MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

Name		Sex 🗆 M 🗆 F Age	Date of birth
☐ Cleared for	r all sports without restriction		
☐ Cleared for	r all sports without restriction with recomme	ndations for further evaluation or treatment for	
□ Not cleared	d		
	Pending further evaluation		
	1 For any sports		
	1 For certain sports		
	Reason		
Recommendat	tions		
I have exam	nined the above-named student and o	completed the preparticipation physical evaluation. 1	The athlete does not present apparent
		pate in the sport(s) as outlined above. A copy of the	
		equest of the parents. If conditions arise after the at	
		e problem is resolved and the potential consequence	es are completely explained to the athlete
(and parent	s/guardians).		
Name of physi	ician (print/type)		Date
EMERGEN	CY INFORMATION		
Allergies			
Other informat	tion		
_			